

Boston Overlap Brace Order Form

Date: _____ Due Date: _____ PO #: _____ Contact: _____
 Ship To: _____ Ship Via: _____ Email: _____
 Address: _____ Account #: _____ Phone: _____
 City: _____ State: _____ Zip: _____ Previous BOB Wearer Scan Label: _____
 Use for reference only

Patient ID: _____ Ht: ___ft ___in Wt: ___lbs
 Age: _____ Sex: _____ Diagnosis: _____



















Measurements taken:

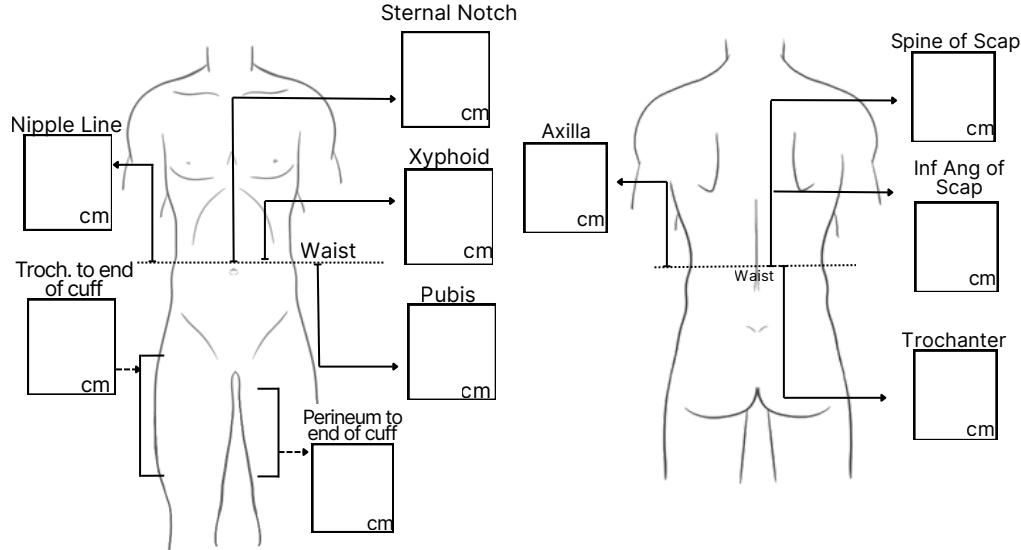
- Standing Supine
 Standard Reduction

Anatomical Measurements

Shape Capture

- Measure Only* Cast Scan
**All measurements required*

	Cir.	M/L	A/P
Xyphoid			
Waist			
ASIS			
Trochanter			
3" Distal to Perineum			
3" Proximal to Knee Center			



Anatomical LENGTHS taken from waist

Brace Modifications

Abdominal Shape

- 10° Abd. Compression
 Neutral
 Refer to measurements

Lordosis

- 15 degrees
 0 degree
 Other: _____

Closure

- BOB Front
 Separate Straps

Brace Design

Liner

- Unlined
 1/8"
 3/16"
 1/4"

Plastic

- 1/8" Polyethylene
 5/32" Polyethylene
 Other: _____

Hip Spica Additions

- Side: Left Right
 Joint Type: Drop Lock B3-ROM
 Cuffs: Detached
 Flexion: _____°
 Abduction: _____°

Scoli Tees

- Single
 Double
 Qty: _____

Finished Heights

Xyphoid: _____ cm Axilla: _____ cm
 Inf Ang Scap: _____ cm Mid Scap: _____ cm
 Pubis: _____ cm Gluteal Fold: _____ cm

- Finish Yes OPSB Trim
 No Customer Trim

Notes: